



## AUTHORIZATION TO RELEASE INFORMATION

<b>Authorization To Release Records Of:</b>			
HEAD OF HOUSEHOLD NAME (LAST, FIRST)		CLIENT ID	
CHILDREN			
<b>Release Information To:</b>			
ORGANIZATION			
ADDRESS		CITY	STATE ZIP CODE
TELEPHONE NUMBER		FAX NUMBER	
<b>Reason For Release:</b>			
<b>The organization above will assist the client in communications with the department, including medical premium billing and payment information. The organization may or may not choose to pay medical premiums on behalf of the children in the household.</b>			
<b>AUTHORIZATION</b>			
<ul style="list-style-type: none"><li>I authorize Economic Services Administration, Medical Assistance Administration and Financial Services Administration to disclose or give access to confidential information about me as described below. Information may be provided verbally, by mail, FAX or by computer data transfer.</li><li>The agencies may disclose information necessary for the administration of Medical program eligibility, including premium billing and payment information.</li><li>The organization will receive the <b>only</b> monthly billing invoice sent concerning premiums for my children's medical coverage provided through the Department of Social and Health Services.</li><li>A copy of this form is valid to give my permission to share information described above.</li></ul>			
<b>AUTHORIZATION WITHDRAWAL</b>			
<ul style="list-style-type: none"><li>I may withdraw this authorization at any time, but that will not affect any information already shared.</li><li>The organization named above may withdraw at any time. If the organization chooses to withdraw as my representative:<ul style="list-style-type: none"><li>They will notify my local CSO by telephone or in writing;</li><li>They will notify me in writing.</li></ul></li></ul>			
<input type="checkbox"/> I choose to have the organization named above receive premium billing invoices and copies of all letters and eligibility reviews sent to me.			
<b>FOR CSO USE ONLY: On the ACES AREP screen, use Rep Type NE and input the organization name and address as listed above.</b>			
<input type="checkbox"/> I choose to have the organization named above receive copies of letters and eligibility reviews sent to me.			
<b>FOR CSO USE ONLY: On the ACES AREP screen, use Rep Type AD and input the organization name and address as listed above.</b>			
<input type="checkbox"/> I choose to have the organization named above receive my premium billing invoices. They will not receive copies of letters or eligibility reviews sent to me.			
<b>FOR CSO USE ONLY: On the ACES AREP screen, use Rep Type XX (new) and input the organization name and address as listed above. This code/option not available until 11/04.</b>			
HEAD OF HOUSEHOLD SIGNATURE		DATE	
ORGANIZATION REPRESENTATIVE SIGNATURE		DATE	